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Office of Administrative Law Judges
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Issue Date: 26 May 2004

In the Matter of:

JOHN D. ADAMS,
Claimant

Case No.: 2003-BLA-6088

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Thomas W. Moak, Esquire
Stumbo, Moak & Nunnery
Prestonsburg, Kentucky
For the Claimant

Theresa Ball, Esquire
Office of the Solicitor
Nashville, Tennessee
For the Director

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits filed under the Black Lung Benefits Act, 30 U.S.C. § 901 et. seq. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2003). In this case, the Claimant, John D. Adams, alleges that he is totally disabled by pneumoconiosis.

A hearing was scheduled for January 15, 2004. By motion received December 9, 2003, the Claimant waived his right to a hearing and requested that a decision be rendered on the

evidence of record. The Director, Office of Workers' Compensation Programs (OWCP) had no objection to his request. By Order dated December 22, 2003, I granted the request and admitted Director's Exhibits ("DX") 1–25 into evidence.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits.

PROCEDURAL HISTORY

The Claimant filed his initial claim on April 20, 1993. DX 1. The claim was denied on reconsideration by the District Director, OWCP, on May 6, 1994. It was denied on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled. The Claimant did not appeal that determination. DX 1.

More than one year later, on December 21, 1995, the Claimant filed a duplicate claim. The duplicate claim was denied by the District Director, OWCP, on May 16, 1996, again on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled. The District Director also found that the Claimant had failed to establish a material change in conditions. The Claimant did not appeal that determination. Less than one year later, on April 16, 1997, the Claimant filed a request for modification. The District Director, OWCP issued a proposed Decision and Order denying benefits on June 2, 1997. The Claimant did not appeal that determination. DX 2.

The Claimant filed his current claim on September 27, 2001. DX 3. The Director issued a proposed Decision and Order denying benefits on February 28, 2003. DX 21. The Claimant requested a hearing, DX 22, DX 23, and the claim was referred to the Office of Administrative Law Judges on June 19, 2003. DX 25.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on September 27, 2001. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2003), as amended at 68 Fed. Reg. 69935 (2003). Pursuant to 20 CFR § 725.309(d) (2003), in order to establish that he is entitled to benefits, Mr. Adams must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, Mr. Adams must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2003). I must consider the new evidence and determine whether Mr. Adams has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Director are:

1. Whether Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2003).

DX 25.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background

The District Director, OWCP, found, and I agree, that the Claimant established 31 years of coal mine employment, including almost 28 years for Southeast Coal Company, which went bankrupt in 1993. DX 4, DX 6, DX 7, DX 8, DX 19, DX 21, DX 25. According to the description of coal mine work prepared by the Claimant, he was employed as a mine foreman from 1965 to 1993; in that capacity, he oversaw mine operations, operated and repaired equipment, walked, crawled and stood most of the day, and was required to lift and carry 50-75 pounds. DX 5. The Claimant's last coal mine employment took place in Kentucky. DX 4. Therefore, the law of the Sixth Circuit governs this claim. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc). The Claimant has no dependents for purposes of augmentation of benefits under the Act. DX 3.

Change in Condition

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The first determination must be whether the Claimant has established with new evidence that he suffers from pneumoconiosis or another pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such an impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on pulmonary or respiratory impairments. Nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits. 20 C.F.R. § 718.204(a) (2003); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991), *aff'd*. 49 F.3d 993 (3rd Cir. 1995). As will be

discussed in detail below, the medical evidence filed in connection with his current claim does not establish that the Claimant has pneumoconiosis or any other pulmonary or respiratory impairment that is totally disabling. Thus I find that he has not established that a change in an applicable condition of entitlement has occurred. It follows that I do not need to address the evidence in the record from his previous claims in explaining my decision that he is not entitled to benefits.

Medical Evidence

Chest X-rays

Chest X-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Any such readings are therefore included in the "negative" column.

Physician qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the List of A and B-readers issued by the National Institute of Occupational Safety and Health (NIOSH).[1] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A = NIOSH certified A-reader; B = NIOSH certified B-reader; BCR = Board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

[1]NIOSH (the National Institute of Occupational Safety and Health) is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as A-readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as B-readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
01/12/99	DX 10 Dr. R. Sundaram (A)[2] 1/1		
08/27/01		DX 10 Dr. Bruce Broudy (B)[3]	
09/17/01	DX 10 Dr. R. Sundaram (A) 2/2		
11/15/01		DX 15 Dr. Nausherwan K. Burki	DX 16 Dr. E. Nicholas Sargent (BCR, B) Read for quality only. Quality 3 film
08/21/02	DX 17 Dr. Glen Baker (B)[4] 1/0		

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 C.F.R. § 718.203(b)(2)(i) (2003).

[2]U.S. Department of Health and Human Services, List of NIOSH Approved B Readers, (visited May 25, 2004) <http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm>.

[3]U.S. Department of Health and Human Services, List of NIOSH Approved B Readers, (visited May 25, 2004) <http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm>.

[4]U.S. Department of Health and Human Services, List of NIOSH Approved B Readers, (visited May 25, 2004) <http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm>; http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 10 01/12/99 Dr. Sundaram	64 66"	2.58	3.11	82	71	No	Mild restriction
DX 10 08/27/01 Dr. Broudy	67 170cm[5]	2.17 2.22	2.62 2.68	83 83	70 67	No No	Mild restrictive defect with no responsiveness to bronchodilation
DX 10 09/17/01 Dr. Sundaram	67 66"	2.38	2.94	82	88	No	Normal spirometry
DX 14 11/15/01 Dr. Burki	67 66"	2.08	2.65	79	---	No	Restrictive defect. No airways obstruction. Reduced ERV suggests restriction secondary to obesity.
DX 17 08/21/02 Dr. Baker	68 66 ¾ "	2.44	3.12	78	---	No	Within normal limits

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial blood oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The following chart summarizes the arterial blood gas studies available in connection with the current claim. A "qualifying" arterial gas study yields values that are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest

[5] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance of up to one inch in the recorded heights of the miner, I have taken the midpoint (66.5") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2003).

Exhibit Number	Date	Physician	pCO_2 at rest	pO_2 at rest	Qualify?	Physician Impression
DX 10	08/27/01	Broudy	35	75	No	
DX 13	11/15/01	Burki	38	73	No	Normal
DX 17	08/21/02	Baker	39	69	No	Mild resting hypoxemia

Medical Opinions

Medical opinions are relevant to the issues of whether a miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a)(4) (2003). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2003). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.202(b)(2)(iv) (2003). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2003). The record contains the following medical opinions submitted in connection with the current claim.

Dr. Raghu R. Sundaram examined the Claimant on January 12, 1999 and on September 17, 2001 in conjunction with the Claimant's pursuit of state benefits. Dr. Sundaram is board-certified in Internal Medicine.[6] In his January 12, 1999 report, Dr. Sundaram took occupational histories, conducted a physical examination, and administered chest x-ray and pulmonary function testing. He also recorded Claimant's subjective complaints. Dr. Sundaram determined that a chest x-ray showed evidence of pneumoconiosis 1/1 and he attributed the pneumoconiosis

[6] The American Board of Medical Specialties (visited May 25, 2004) http://www.abms.org>.

to prolonged exposure to coal dust. He also concluded that the Claimant was unable to perform his previous coal mine employment due to shortness of breath with limited activity. In his September 17, 2001 report, Dr. Sundaram took occupational histories, conducted a physical examination, and administered chest x-ray and pulmonary function testing. He also recorded Claimant's subjective complaints. Dr. Sundaram determined that a chest x-ray showed evidence of pneumoconiosis 2/2 and he attributed the pneumoconiosis to "40 years of exposure to coal dust." He again concluded that the Claimant was unable to perform his previous coal mine employment, for the same reason as before. DX 10.

Dr. Bruce Broudy examined the Claimant on August 27, 2001, also in conjunction with his pursuit of state benefits. Dr. Broudy is Board-certified in Internal Medicine and Pulmonary Disease.[7] Dr. Broudy took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. He also recorded Claimant's subjective complaints. Dr. Broudy reported that the pulmonary function study showed a "mild restrictive defect with no responsiveness to bronchodilation," and that the arterial blood gas was "normal." Dr. Broudy concluded that the Claimant did not have coal workers' pneumoconiosis, and that the Claimant's restrictive defect "may be related to obesity." He also wrote "there is no evidence of any restrictive pulmonary disease by chest x-ray." He found no disease associated with coal dust exposure and no pulmonary impairment due to coal dust exposure. DX 10.

Dr. Nausherwan K. Burki examined the Claimant on November 15, 2001, on behalf of the Director. Dr. Burki is Board-certified in Internal Medicine and Pulmonary Disease.[8] He took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. He characterized the chest x-ray and arterial blood gas as normal, and said the vent study showed a restrictive defect. He noted that the Claimant had never smoked. Dr. Burki concluded that the Claimant had a "restrictive pulmonary defect" with a "mild" impairment due to obesity. Dr. Burki reported that the Claimant did not have the ability to perform his previous coal mine or comparable work due to his "restrictive defect secondary to obesity." DX 12.

Dr. Glen R. Baker examined the Claimant on August 21, 2002, at his counsel's request. Dr. Baker is Board-certified in Internal Medicine and Pulmonary Disease.[9] He took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. He also recorded Claimant's subjective complaints. He noted that the Claimant had never smoked. Dr. Baker found that the Claimant had coal workers' pneumoconiosis on the basis of the x-ray (1/0) and his history of coal dust exposure. He reported

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[7]The American Board of Medical Specialties (visited May 25, 2004) <http://www.abms.org>.

[8]The American Board of Medical Specialties (visited May 25, 2004) <http://www.abms.org>.

[9]The American Board of Medical Specialties (visited May 25, 2004) <http://www.abms.org>.

that the Claimant also had chronic bronchitis, with history of cough, sputum production, and wheezing, due to coal dust exposure. Dr. Baker said that pulmonary function testing was within normal limits, and that the Claimant had "mild resting arterial hypoxemia" on his arterial blood gas studies. Dr. Baker rated the Claimant's impairment as "minimal or none," and said that he had the respiratory capacity to perform the work of a coal miner. DX 17.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those disease recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2003).

20 C.F.R. § 718.202(a) (2003) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in § 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), § 718.305 (not applicable to claims filed after January 1, 1982), or § 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung

biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314–315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987); *Eastern Associated Coal. Corp. v. Director*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148, 1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the five x-rays in this case, three have been read as positive and two as negative for pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 C.F.R. 718.202(a)(1) (2003); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213, n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *Adkins*, 958 F.2d at 52.

The x-ray taken on January 12, 1999 was read as positive for pneumoconiosis by Dr. Sundaram (1/1), an A-reader. There are no other readings of this x-ray.

The x-ray taken on August 27, 2001 was read as negative by Dr. Broudy, a B-reader. There are no other readings of this x-ray.

The x-ray taken on September 17, 2001 was read as positive for pneumoconiosis by Dr. Sundaram (2/2). There are no other readings of this x-ray.

The x-ray taken on November 15, 2001 was read as negative for pneumoconiosis by Dr. Burki. There are no other readings of this x-ray, except for a film quality reading by Dr. Sargent.

The x-ray taken on August 21, 2002 was read as positive for pneumoconiosis by Dr. Baker (1/0), a B-reader. There are no other readings of this x-ray.

Although more x-rays were read as positive than negative, I do not find that these positive readings are entitled to more weight. First, I give less weight to Dr. Sundaram's positive readings as he is not a B-reader or a Board-certified radiologist. In addition, the most recent x-ray was interpreted by Dr. Baker (a B-reader) as 1/0. Dr. Sundaram interpreted the September 17, 2001 x-ray as 2/2. Because Dr. Baker is a B-reader, I find that this report raises questions about the reliability of Dr. Sundaram's findings which were taken a year earlier and yet indicate a much higher classification. Moreover, in addition to Dr. Baker, Dr. Broudy is also a B-reader. I find that Dr. Baker's positive reading from August 2002 is countered by Dr. Broudy's negative reading from a year earlier in August 2001. Thus I conclude that the Claimant has not established the existence of pneumoconiosis by virtue of the x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. See *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Whether a medical report is sufficiently documented and reasoned is for the judge to decide as finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a miner's treating physician as he or she is more likely to be familiar with the miner's condition than a physician who only examined

the miner episodically. O*nderko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). In this case, however, there are no treatment records in evidence.

The conflicting medical opinions must be weighed to resolve the contrary conclusions. All of the physicians who provided medical opinions did so based on equivalent underlying documentation. All provided at least some rationale in support of their conclusions. Thus I consider all of these medical opinions to represent documented and reasoned medical opinions.

Dr. Baker and Dr. Sundaram diagnosed pneumoconiosis, while Dr. Burki and Dr. Broudy did not. Dr. Baker, Dr. Burki and Dr. Broudy are all Board-certified pulmonologists, whereas Dr. Sundaram does not possess that qualification. In addition, Dr. Baker relied significantly upon the chest x-ray from August 2002 for his diagnosis. There is no indication in the record that he was aware of the other x-ray readings, examination results, or medical opinions. Because I have found that the X-ray evidence as a whole does not support a finding of pneumoconiosis, Dr. Baker's reliance on his one x-ray reading detracts from the weight to be given his opinion. I conclude that Dr. Burki's and Dr. Broudy's opinions are entitled to greater weight. Thus I also find that the physician opinion evidence does not support a finding of pneumoconiosis. Moreover, considering all of the relevant medical evidence together, I conclude that the Claimant has failed to establish the existence of pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921 (c)(1); 20 C.F.R. § 718.203(b) (2003). As Claimant has established 31 years of coal mine employment, he would be entitled to the presumption. I find, however, that this issue need not be addressed further, as Claimant has failed to show that he has pneumoconiosis.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921 (c)(3), 20 C.F.R. § 718.304 (2003), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b) and (c) (2003). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion, and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d) (2003). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) (2003); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

There are no pulmonary function studies or arterial blood gas studies that produced qualifying results. Indeed, the test results were characterized as either normal, or showing mild impairment.

All physicians who examined the Claimant agree that the Claimant has some degree of impairment. Two physicians, Dr. Sundaram and Dr. Burki, concluded that the Claimant would be unable to perform his previous coal mine employment, but the other two physicians who gave opinions disagreed. In any event, Dr. Burki believed the Claimant did not have pneumoconiosis, and that his restrictive impairment was due to obesity, so Dr. Burki's opinion would not support the conclusion that any disability was caused by pneumoconiosis. Dr. Sundaram's opinion was based on the Claimant's subjective symptoms. Moreover, even though Dr. Baker thought Mr. Adams had pneumoconiosis, he did not believe he was disabled from coal mine work. I give greater weight to the opinions of Dr. Baker and Dr. Broudy, as they are more consistent with the results of the objective tests and the weight of the medical evidence as a whole. Thus, I conclude that the Claimant does not have a total respiratory or pulmonary disability.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to the Claimant's disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 C.F.R. § 718.204(c) (2003); *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734 (3rd Cir. 1989). As I have found that the evidence does not establish that the Claimant has pneumoconiosis, he cannot establish that pneumoconiosis is a substantial contributor to his disability.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish either that there has been a change in one of the applicable conditions of entitlement since the denial of his previous claim became final, or that he is totally disabled due to pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by John D. Adams on September 27, 2001, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2003), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.